DOCUMENT RESUME

ED 327 803 CG 023 107

AUTHOR Bihm, Elson M.; And Others
TITLE Effects of Aversive Versus Positive Behavioral Treatment, Treatment Setting, and Client IQ on Person Perception.
PUB DATE Aug 90
NOTE 15p.; Paper presented at the Annual Convention of the American Psychological Association (98th, Boston, MA, August 10-14, 1990).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Antisocial Behavior; *Attribution Theory; *Behavior Modification; College Students; Higher Education; Institutionalized Persons; Intelligence Quotient; *Labeling (of Persons); *Mental Retardation; *Place of Residence

ABSTRACT

This study explored the effects of type of behavioral treatment and living environment on college students' (N=216) person-perceptions and causal attributions of deviant behaviors of a 17-year-old with mental retardation or normal intelligence. The results suggested that positive behavioral approaches and normalized community settings, at least as described in this study, were deemed more acceptable to the students, who also believed the positive treatments would be more likely to work. Positive behavioral treatments and normalized community settings were associated with greater perceptions of person-competency and future progress. Similar positive evaluations of competencies and expectations for progress were made for clients labeled as having normal intelligence. An analysis of causal attributions suggested that the causes of deviant behaviors of persons in institutional settings were seen as more controllable by the client, while the label of mental retardation was associated with causes perceived as less controllable, more stable, and less the result of others. (The clinical implications for the social validity of behavioral treatments, environmental settings, and handicapping labels, as well as the organization of person-beliefs and the causal-structure of these beliefs, are discussed.) (Author)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED327803

Paper submitted to:

APA Convention (1990)

Boston, Massachusetts

Effects of Aversive versus Positive Behavioral Treatment, Treatment Setting, and Client IQ on Person Perception

Elson M. Bihm

University of Central Arkansas

Carol K. Sigelman

University of Arizona

Sandra M. Kennedy

University of Central Arkansas

Running head: AVERSIVE VERSUS POSITIVE BEHAVIORAL TREATMENT

CG023107

This study was funded by a grant (212-239) from the University Research Council of the University of Central Arkansas. We acknowledge the invaluable assistance of Lisa M. Matthews Wood with preparation of this manuscript.

Correspondence concerning this presentation should be addressed to Elson M. Bihm, Department of Psychology and Counseling, University of Central Arkansas, Conway, AR 72032.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Elson M. Bihm

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Abstract

This study explored the effects of type of behavioral treatment and living environment on college students' (N = 216) person-perceptions and causal attributions of deviant behaviors of a 17-year-old with mental retardation or normal intelligence. The results suggested that positive behavioral approaches and normalized community settings, at least as described in this study, were deemed more acceptable to the students, who also believed the positive treatments would be more likely to work. Positive behavioral treatments and normalized community settings were associated with greater perceptions of person-competency and future progress. Similar positive evaluations of competencies and expectations for progress were made for clients labeled as having normal intelligence. An analysis of causal attributions suggested that the causes of deviant behaviors of persons in institutional settings were seen as more controllable by the client, while the label of mental retardation was associated with causes perceived as less controllable, more stable, and less the result of others. The clinical implications for the social validity of behavioral treatments, environmental settings, and handicapping labels, as well as the organization of person-beliefs and the causal-structure of these beliefs, are discussed.

EFFECTS OF AVERSIVE VERSUS POSITIVE BEHAVIORAL TREATMENT, TREATMENT SETTING, AND CLIENT IQ ON PERSON PERCEPTION

In a series of pioneering studies, Kazdin (1980, 1981; Kazdin, French, & Sherick, 1981) established that reductive, punitive, or aversive techniques are judged less appropriate, fair, and reasonable than positive behavioral techniques such as the reinforcement of incompatible behavior. Uniformly, the focus of these studies has been on people's perceptions of treatments, without regard to their perceptions of the individuals to whom these treatments are applied. Yet, as Guess, Helmstetter, Turnbull, and Knowlton (1987) speculate, individuals who treated in what appears to be a punitive manner might be devalued as individuals.

For example, research on the just world hypothesis suggests that individuals who witness another person receiving unfair treatment tend to lower their evaluations of that individual (Lerner, 1965; Lerner & Miller,1978). Also, attribution theory, particularly Weiner's (1986) version of it, is germaine, for it specifies relationships between attributions for problem behaviors and emotional responses to people with problems.

We presented college students with a case description of an individual who has severe behavior problems, manipulating the nature of the behavioral treatment he received (positive or aversive), the setting in which he was being treated (foster home

in the community versus institution), and his level of intelligence (severely mentally retarded, mildly mentally retarded, or nonretarded). Using a battery of scales, we measured not only evaluations of the treatment and the treatment setting but perceptions of the causes of the individual's problems and of his competence, level of adjustment, likability, desirability as a social partner, and chances of future success.

Method

Subjects

The subjects were 216 college undergraduates attending a state university. The average age was 21.42 (*SD* = 5.51).

Stimulus Materials and Independent Variables

Behavioral Description. This description (read by all participants) stated that John's behavior was a source of great concern because it sometimes endangered John or other people. It was reported that he had frequent episodes in which he would shove and hit other people or throw things at them; that he often failed to comply with requests to do certain tasks; that he would sometimes yell or scream at those around him; and that when he was highly stressed, he would bite the back of his hand so severely he would draw blood or bang his head against the wall or floor. It was pointed out that he was difficult to control because he was above average in height and strength.

Behavioral Programming. The "positive" behavioral program

was described as being based upon reinforcement procedures.

The "aversive" behavioral program was designed to bring the deviant behaviors under control through aversive procedures.

Living Arrangements. In the "community setting" condition, John was described as living with foster parents in a home located in a middle class neighborhood in the community.

In the "institution setting" condition, John was described as living in a large institution that provided services to 450 children and adolescents, and that was located in the country away from John's community.

Intelligence Levels. In the "severe/profound mental retardation" condition, John was described as having extremely low general intelligence, with an IQ of 20.

In the "mild mental retardation" condition, John was described as having low general intelligence (an IQ of 60).

In the "normal intelligence" condition, John was described as having "average" general intelligence (an IQ of 100).

Dependent Variables

The second booklet contained the dependent measures. These consisted of in order: (a) scales measuring opinions about the treatment and about the setting; (b) causal attribution items drawn from Russell's Causal Dimension Scale (Russell, 1982); (c) an adjective rating scale patterned after scales devised by Heilman and Stopeck (1985) and Major, Carnevale, and Deaux

(1981); (d) a social distance scale adapted from Triandis (1964); (e) a measure of expectations regarding future progress; and (f) recall and manipulation check items, as well as demographic questions.

Results and Discussion

The MANOVA analyses did not suggest any significant two- or three-way interactions between the independent variables. However, the main effect of Program was significant (Wilks's Lambda = .53; F [13, 192] = 12.98, p = .000) -- see Table 1. So was effect of Setting (Wilks's Lambda = .72; F [13, 192] = 5.72, p = .000) -- see Table 2. And the effect of Intelligence (Wilks's Lambda = .52; F [26, 384] = 5.70, p = .000) -- see Table 3.

Individual F-test comparisons revealed that the subjects in this study viewed aversive behavioral programming as less acceptable (p = .000), and they did not believe that such methods were likely to be successful (p = .000). Persons being treated with positive techniques were viewed as more competent (p = .049) and more likely to succeed in the future (p = .006).

Not only were positive approaches viewed as more acceptable, but so were community settings (p = .000). Persons in the community were also viewed as more competent (p = .026) and as having a greater potential for success (p = .015). In the institutional condition, there was a tendency to see the main cause of the behavior as controllable by the client (p = .001),

who may have been seen as more responsible for his deviant behavior.

Deviant behavior is seen as more severe when exhibited by mentally retarded persons ($p = .016$), and the cause of this behavior is viewed as being more stable in mentally retarded persons, which seems reasonable if the deficits were viewed as a function of "retardation" (Gibbons, et al., 1979; Severance & Gasstrom, 1977). Other persons were viewed as less responsible for the behaviors of mentally retarded persons ($p = .027$). The reasons are unclear. Perhaps others may be less likely to be able to control the mental retardation itself. Also, mentally retarded persons were seen as less competent ($p = .000$) and the students expected less progress from them ($p = .011$).

Our subjects were able to infer certain relations among behaviors and environmental events, which may have implications for treatment: certain treatments and settings were clearly unacceptable, yet at the same time, persons in such settings were seen as less competent. Also, certain dimensions of causality were associated with certain settings and intellectual levels, and intellectual levels were in turn correlated with perceptions of the severity of the behavior. Thus we may tend to devalue competencies and potentials as a function of the treatment and living environment, and make different causal attributions based on setting and person labels. Finally, our research suggests that researchers, clinicians, and policy makers might add another

dimension to the evaluation of services for disabled persons: the extent to which these services enhance the social image of the individual.

References

Gibbons, F.X., Sawin, L.G., & Gibbons, B.N. (1979). Evaluations of mentally retarded persons: Sympathy or patronization? American Journal of Mental Deficiency, 84, 124-131.

Guess, D., Helmstetter, E., Turnbull, H.R., & Knowlton, S. (1987). Use of aversive procedures with persons who are disabled: A historical review and critical analysis. Monograph of the Association for Persons with Severe Handicaps, (Vol. 2, No.1, p. 32).

Heilman, M.E. & Stopeck, M.H. (1985). Attractiveness and corporate success: Different causal attributions for males and females. Journal of Applied Psychology, 70, 379-388.

Kazdin, A.E. (1980). Acceptability of alternative treatments for deviant child behavior. Journal of Applied Behavior Analysis, 13, 259-273.

Kazdin, A.E. (1981). Acceptability of child treatment techniques: The influence of treatment efficacy and adverse side effects. Behavior Therapy, 12, 493-506.

Kazdin, A.E., French, N.H. & Sherick, R.B. (1981). Acceptability of alternative treatment for children: Evaluations by inpatient children, parents, and staff. Journal of Consulting and Clinical Psychology, 49, 900-907.

Lerner, M.J. (1965). Evaluation of performance as a function of performer's reward and attractiveness. Journal of Personality and Social Psychology, 1, 355-360.

Lerner, M.J., & Miller, D.T. (1978). Just world research and the attribution process: Looking back and looking ahead. Psychological Bulletin, 85, 1030-1051.

Major, B., Carnevale, P.J.D., & Deaux, K. (1981). A different perspective on androgyny: Evaluations of masculine and feminine personality characteristics. Journal of Personality and Social Psychology, 41, 988-1001.

Russell, D. (1982). The causal dimension scale: A measure of how individuals perceive causes. Journal of Personality and Social Psychology, 42, 1137-1145.

Severance, L.J., & Gasstrom, L.L. (1977). Effects of the label "mentally retarded" on causal explanations for success and failure outcomes. American Journal of Mental Deficiency, 81, 547-555.

Triandis, H.C. (1964). Exploratory factor analysis of the behavioral component of social attitudes. Journal of Abnormal and Social Psychology, 68, 420-430.

Weiner, B. (1986). An attributional theory of motivation and emotion. New York: Springer Verlag.

Table 1

Means, Standard Deviations, and Significant Univariate F-tests of the 13 Dependent Variables as a Function of Type of Program (Positive or Aversive).

Scale (Maximum)	Program	
	Positive	Aversive
	Mean (SD)	Mean (SD)
Severity of behavior (9)	6.67 (1.54)	6.92 (1.50)
Acceptability of treatment (18)	14.99 (2.69)	8.63 (4.83)[a]
Expectations for treatment (18)	11.84 (2.71)	8.86 (3.35)[b]
Acceptability of setting (18)	11.98 (4.24)	10.88 (4.30)[c]
Cause: Internal to John (27)	16.33 (5.33)	16.28 (5.07)
Cause: Controllable by John (27)	12.44 (5.21)	12.32 (5.15)
Cause: Stable (18)	8.74 (3.73)	9.04 (3.39)
Cause: Other persons (36)	19.62 (6.81)	18.90 (6.40)
Likability (45)	20.39 (6.67)	19.04 (6.33)
Adjustment (54)	18.56 (8.37)	17.15 (8.73)
Competency (72)	32.67 (10.77)	30.30 (10.61)[d]
Social distance (108)	75.76 (18.44)	74.77 (18.20)
Expectations for progress (36)	32.30 (4.24)	30.44 (5.74)[e]

[a] $F(1, 204) = 141.54$, $p = .000$

[b] $F(1, 204) = 51.77$, $p = .000$

[c] $F(1, 204) = 4.38$, $p = .038$

[d] $F(1, 204) = 3.93$, $p = .049$

[e] $F(1, 204) = 7.74$, $p = .006$

Table 2

Means, Standard Deviations, and Significant Univariate F-tests of the 13 Dependent Variables as a Function of Type of Setting (Community or Institution).

Scale (Maximum)	Setting	
	Community	Institution
	Mean (SD)	Mean (SD)
Severity of behavior (9)	6.75 (1.41)	6.83 (1.63)
Acceptability of treatment (1)	11.93 (5.01)	11.69 (5.08)
Expectations for treatment (1)	10.47 (3.41)	10.23 (3.38)
Acceptability of setting (18)	13.31 (3.44)	9.55 (4.25)[a]
Cause: Internal to John (27)	15.64 (5.58)	16.97 (4.71)
Cause: Controllable by John (27)	11.31 (5.26)	13.44 (4.87)[b]
Cause: Stable (18)	9.20 (3.73)	8.57 (3.37)
Cause: Other persons (36)	19.52 (7.34)	19.00 (5.79)
Likability (45)	20.50 (6.22)	18.93 (6.75)
Adjustment (54)	18.74 (8.30)	16.96 (8.77)
Competency (72)	32.82 (10.70)	30.14 (10.63)[c]
Social distance (108)	76.74 (17.73)	73.79 (18.79)
Expectations for progress (36)	32.19 (4.42)	30.55 (5.63)[d]

[a] F (1, 204) = 51.20, p = .000

[b] F (1, 204) = 10.96, p = .001

[c] F (1, 204) = 5.05, p = .026

[d] F (1, 204) = 6.00, p = .015

Table 3

Means, Standard Deviations, and Significant Univariate F-tests of the 13 Dependent Variables as a Function of Type of Intelligence Level (Average, Mild, or Severe/Profound).

Scale (Maximum)	Intelligence Level		
	Average	Mild	Severe/ Profound
	Mean (SD)	Mean (SD)	Mean (SD)
Severity of behavior (9)	6.40 (1.66)	6.86 (1.37)	7.11 (1.46)[a]
Acceptability of treatment (18)	11.61 (5.28)	11.75 (4.85)	12.07 (5.03)
Expectations for treatment (18)	9.76 (3.68)	10.36 (3.16)	10.93 (3.24)
Acceptability of setting (18)	11.60 (4.49)	11.07 (4.38)	11.63 (4.05)
Cause: Internal to John (27)	16.22 (4.56)	15.82 (5.77)	16.88 (5.19)
Cause: Controllable by John (27)	14.86 (5.19)	11.22 (4.19)	11.06 (5.19)[b]
Cause: Stable (18)	7.88 (3.73)	9.46 (3.04)	9.33 (3.69)[c]
Cause: Other persons (36)	20.96 (6.27)	18.36 (7.00)	18.46 (6.26)[d]
Likability (45)	20.51 (6.62)	19.00 (6.83)	19.63 (6.08)
Adjustment (54)	18.97 (8.32)	17.69 (8.89)	16.83 (8.46)
Competency (72)	39.86 (8.72)	28.00 (8.86)	26.58 (9.29)[e]

Social distance (108)	76.18(15.83)	73.32(21.66)	76.29(16.94)
Expectations for progress	32.79 (4.01)	30.81 (4.89)	30.50 (6.01)[f]

[a]F (2, 204) = 4.23, p = .016

[b]F (2, 204) = 14.91, p = .000

[c]F (2, 204) = 4.52, p = .012

[d]F (2, 204) = 3.70, p = .027

[e]F (2, 204) = 49.63, p = .000

[f]F (2, 204) = 4.61, p = .011